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X-RAY TREATMENT OF MALIGNANT LYMPHOMA*

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WITH THE EXCEPTION of radical surgery in selected localized cases and the more recent use of the nitrogen mustards and certain radioactive isotopes, malignant lymphoma has been treated almost entirely by x-ray. With regards to the surgical approach, C. A. Hellweg reported a 5 year survival in twenty-one cases which received no other form of therapy.

Since the beginning of our tumor clinic here at Memorial Hospital, we have had about twenty-three cases of malignant lymphoma, all of which have been confirmed by pathologic study. This series is too small to warrant any conclusions, but in general, it can be stated that they fall into the same groups described by Dr. Williams and as reported at larger institutions. Among the more numerous of the types that are encountered are the Hodgkins granulomas and the follicular type of malignant lymphoma. Of the various types, Hodgkin's disease shows a good survival period. Known cases of Hodgkin's disease have been followed longer than twenty years. Cases where the disease has remained localized, in general, offers the best prognosis. On the other hand, lymphocarcoma, when generalized, carried a distinctly poor prognosi.

X-ray therapy, in general, is divided into two types. One is the generalized type of x-ray therapy, where the whole body or a large portion of it, receives simultaneous radiation with the x-ray tube placed at a considerable distance from the patient. This form of therapy, sometimes referred to as "spray radiation" requires only very small dosages, but often produces a very dramatic effect. Furthermore, this is a rather dangerous form of x-ray treatment, since the reaction of the patient may be so marked and generalized as to produce a profound state of shock for which even emergency measures such as transfusions, etc., are often of no avail. For this reason, and because the ultimate results are not particularly better than those obtained by regional or topical application of x-ray, this generalized form of x-ray treatment has not achieved any appreciable degree of popularity among radiologists. Nevertheless, it is useful in certain cases, especially where the patient has become refractory to previous x-ray therapy.

The other form of x-ray treatment, namely the regional or topical type, is the one which is being largely used, and the only one that has been employed at this hospital.

The x-ray treatment, in general, is given only when and if indicated from a clinical standpoint. The mere presence of a mass shown by pathologic study to be some form of malignant lymphoma is not in itself indication for the application of roentgen irradiation. It is to be kept in mind, of course, that this refers principally to the generalized type of malignant lymphoma since the present trend in so-called localized cases is to attempt a cure by either surgery or very intensive irradiation. The clinical indications for treatment of the generalized type of malignant lymphoma are based on several criteria:

1. marked enlargement of the glands already present
2. the appearance of glands at new locations
3. anemia
4. change in blood picture such as distinct rise in the white blood count
5. marked enlargement of the spleen or liver which has occurred since a previous observation
6. the occurrence of intestinal bleeding
7. malaise, loss of weight, weakness, or other changes in the state of well being

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* Presented at the John F. Kenny Annual Clinic of The Memorial Hospital Internes' Alumni Association, at Pawtucket, R. I., November 10, 1948.

X-ray treatment when indicated, is given over the involved regions using one or two areas at a sitting and other areas on the following day or a few days later, returning to the original area in about three to four days.

Most of the malignant lymphomas, with perhaps the exception of certain types of lymphocarcoma, are generally very radio-sensitive and one obtains almost universally a shrinkage of the lymphoma masses. This shrinkage can be obtained not only of the superficial masses involving the glands, but even the more deep-seated tumors in the mediastinum or abdominal cavity. Once the diagnosis of malignant lymphoma has been established, one need not wait before treating new symptoms, even though a mass is not felt. For example, we have had cases of Hodgkin's disease that developed gastro-intestinal symptoms and radiation was applied over the abdomen, even though a specific mass was not delineated. A word of caution should be noted regarding lymphomatous involvement of the intestinal canal. In a personal communication, I have learned of a patient with lymphoma of the stomach who was given x-ray therapy in the usual small dosages and this was followed by perforation through the gastric wall. It was felt that the lymphoma had involved the several layers of the stomach and the very rapid disintegration of the tumor in response to x-ray therapy lead to this complication. Another example is a case of cervical Hodgkins which developed weakness in both lower extremities, rapidly progressing to a diplegia. X-ray therapy to the lumbar area resulted in a prompt disappearance of the paralysis. These cases responded to such treatment, and the assumption was that Hodgkin's involvement was present.

I should like to spend a moment regarding dosage in malignant lymphoma. As I have already stated, the malignant lymphomas, in general, are very sensitive to roentgen irradiation. Up to very recently, dosages have been rather small, certainly as compared with x-ray dosages given to tumors of epithelial origin, namely the carcinomas. Until very recently, the x-ray treatment of malignant lymphoma has varied between ten and thirty per cent of the dosage given to carcinoma.

In the past few years, there has been a definite trend toward increasing the x-ray dosage for malignant lymphoma and recently, the Lahey Clinic in Boston has increased their dosage from two to three times what had previously been given. For example, in Hodgkin's disease involving the mediastinum, the previous dosage was approximately 800 to 1200 "r", as measured in air over the skin and at the Lahey Clinic, they are now delivering 2500 "r", into the tumor, which corresponds to about 5000 "r", on the skin surface. I have been inclined to follow this trend, particularly in those cases which present some element of localization. For example, when a case presents manifold involvement of the lymph glands over several regions of the body, I am still confining my dosage to the small amounts previously given. However, where only one group of glands are involved or perhaps two area, or where only the mediastinum seems to show involvement, then I am giving much greater dosages.

In general, our results with x-ray therapy for malignant lymphoma have been of no avail from the standpoint of a cure, but as regards prolongation of life with alleviation of symptoms, our results are encouraging. This is particularly so in Hodgkin's disease where most of the patients are restored to a state of relative well-being and practically all of them have been able to return to work.

Encouraging also is that type of malignant lymphoma with a leukemic type of blood picture, the lymphocytic type of malignant lymphoma. About a month ago, one of these lymphocytic types became rather acutely anemic with low red cell count and low hemoglobin. The blood picture also showed a distinct leukemic trend with a high relative lymphocyte count. Radiation in small doses was promptly administered over several areas of glandular enlargement—the axillae, groins, and both cervical regions. Three weeks later, the blood count was approaching normal, the patient felt considerably improved, and had gained nine lbs. in weight.

Here is a case that illustrates the indication for x-ray therapy in malignant lymphoma. He was treated not because he had glandular enlargement, but because of the weakness and blood picture.

PROVIDENCE MEDICAL ASSOCIATION

Next Meeting: **Monday, April 4**

THE PATHOLOGY OF MALIGNANT LYMPHOMA*

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MALIGNANT LYMPHOMA includes all primary neoplasms of lymph nodes and lymphatic tissue throughout the body. It embraces such conditions designated as lymphosarcoma, lymphatic leukemia and Hodgkins Disease. It is realized that there are many moot points in question and that this definition is dogmatic.

Kundrat in 1893 described certain malignant lymphomas, termed by him lymphosarcoma, as arising in a single regional group of lymph nodes, or in a single locus in the lymphatic tissue of mucous membranes. Additional evidence has accumulated in late years that certain of the lymphomas, including Hodgkins Disease, may be unicentric in origin, and, theoretically at least, it should be possible to eradicate such with some form of extirpation therapy i. e., surgery, radiation, or both.

For example, Baker and Mann reported two cases of unilaterial cervical Hodgkins Disease, treated by surgery and post operative radiation, which survived ten and twelve years, respectively. Slaughter and Craver in 1942 reported five cases of Hodgkins, apparently localized to one nodal region, which were treated by surgery, followed by local Roentgen irradiation. Survival was from five to eleven years.

Sugarbaker and Craver in 1940 reported twenty-five cases of lymphosarcoma, apparently localized to an extranodal site or a regional group of nodes. They were treated by surgical extirpation and followed, in most cases, by local external irradiation. Six, or 24%, were living and free of disease five or more years later. Catlin reported on the therapy of fifty cases of lymphosarcoma, apparently localized to the head and neck, and found that the five year survival rate was 52%.

This suffices to indicate that we must give more attention to the concept that at least a certain small number of the malignant lymphomas may be unicentric in origin.

Most cases, however, when they first come under observation, have obviously widespread disease and the multicentric origin of neither these nor the above-cited cases can be lightly dismissed. In such generalized cases the pathology indicates palliative therapy, only.

While no classification is completely satisfactory, the one to be presented serves as a useful working tool. It is based on cytological and histological criteria and does not take into account such findings as the blood picture or general behavior of the disease. It it taken from the publication of Gall and Mallory with modifications by Clarke.

Classification of Malignant Lymphoma:

1. Lymphocytic type.
2. Lymphoblastic type.
3. Reticulum cell type.
4. Follicular type.
5. Hodgkins Disease.

Complete, or almost complete, obliteration of the architecture of the involved organ, usually a lymph node, is a necessary requisite for the histological diagnosis of all malignant lymphomas. In those designated as lymphocytic, lymphoblastic and reticulum cell type, the cellular structure is made up, predominantly, of these cells. The lymphocyte of malignant lymphoma is indistinguishable from the normal lymphocyte and it is not possible, on histological grounds, to determine whether a leukemic blood picture is present. The lymphoblast is ten to twenty microns in diameter and possesses a narrow basophilic rim of cytoplasm about a round or slightly indented, vesicular nucleus. Nucleoli are infrequently observed. The reticulum cell varies from fifteen to thirty-five microns in diameter. It has abundant, pale-staining cytoplasm, a large, delicate nucleus, frequently containing a nucleolus. The cells are arranged as solid sheets without clearly discernible cell borders. This latter group is admittedly an ill-defined one and pathologists frequently disagree as to what is and is not a reticulum cell type of malignant lymphoma.

The histology of Hodgkins Disease in a typical case presents a polymorphous, cellular picture, consisting of lymphocytes, plasma cells, eosinophils, reticular cells, and a variable number of typical

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* Presented at the John F. Kenny Annual Clinic of The Memorial Hospital Internes' Alumni Association, at Pawtucket, R. I., November 10, 1948

A SIMPLE PLASTIC OPERATION FOR STENOSED COLOSTOMIES

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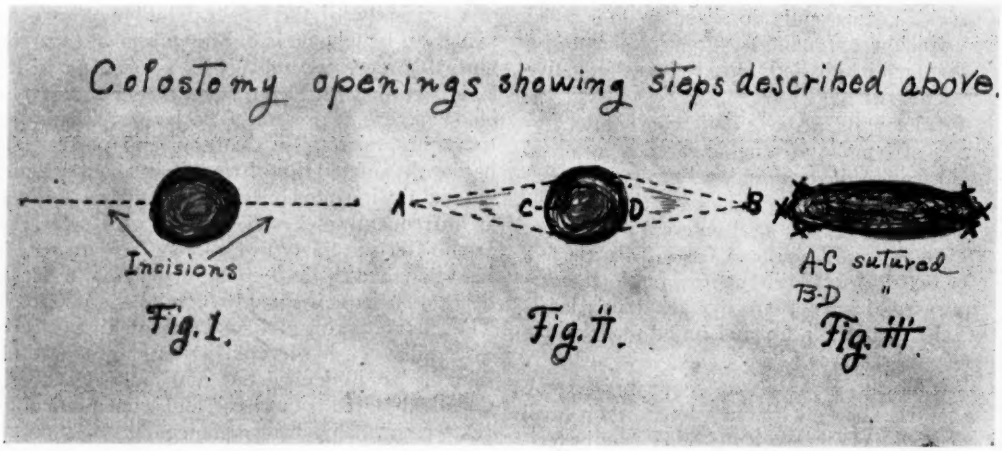
NOT INFREQUENTLY a colostomy will become constricted at the skin orifice to such a degree that a partial obstruction results. Such a stenosed colostomy opening may develop in some patients even though a good segment of the bowel is originally left external to the skin surface and the wound heals by first intention. Routine gentle digital dilatation of colostomy, postoperatively, may fail to prevent the ultimate occurrence of the complication.

A simple plastic procedure has been found useful in the correction of the contracted colostomy opening which is described as follows:—

The operation may be done at the office. Novocaine 20cc of 1% solution sould give satisfactory local anesthesia. The patient should thoroughly irrigate the bowel through a catheter the preceding evening. Two skin incisions 2.5cm in length are made from opposite sides of colostomy opening. These incisions extend about 1.5cm into fat layer, and to the external skin margin of the bowel. (Fig. No. 1) A 0.5 cm nick is made on each side of bowel margin to release a bit the fibrous ring which is found about the colostomy margin. The above incisions have now opened up two triangular areas on opposite sides of the colostomy opening. (Fig. No. 2) The next step consists in suturing the skin apex of triangular space to free margin of bowel on either side, using interrupted "C" silk. A few extra sutures appose skin margin to bowel edge on either side of first key sutures. (Fig. No. 3) All sutures out by sixth day.



DIABETIC LIPOIDIC NECROBIOTIC DERMATITIS

(Necrobiosis Lipoidica Diabeticorum Urbach)

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MOST DERMATOSES are manifestations of internal diseases or, if purely external, like impetigo, scabies, the tineas, etc., are often under the influence of internal conditions. Books apparently devoted solely to skin manifestations of internal diseases, are in reality the same books on diseases of the skin with a novelty appealing title.

Of special practical importance are the skin manifestations giving a definite lead to the diagnosis of an internal disease. Manifestations of such a kind are few. A conspicuous, peculiar and fairly frequent dermatosis definitely related to diabetes was first described by Oppenheim.[1] He named it dermatitis atrophicans lipoides. Urbach[2] in 1932, studied a similar case, and called it necrobiosis lipoidica diabeticorum, which name has remained in medical literature. Since then, cases have been reported by Balbi[3], Zeisler and Caro,[4] and others.[5]

Necrobiosis lipoidica diabeticorum is a localized cutaneous lipoidosis most often encountered in association with diabetes mellitus. In more than 87.2 per cent of the reported cases, diabetes was present, in severe or moderately severe form. Examples of the disease have been recorded in non-diabetic patients, and the latter presented a fairly high incidence of vaso-motor instability and hypertension. (Boldt.[6]) According to Ormsby and Montgomery[7] it is possible that necrobiosis lipoidica diabeticorum, when observed in a patient without diabetes, merely represents a prodromal stage, and that diabetes will ultimately develop. Cutaneous lesions may appear several months or years after onset of diabetes. However, there have been cases in which lesions preceded the onset of diabetes by as much as eight years.

The common site of occurrence of the skin lesions is one or both legs, below the knee. The individual lesion is a small, round or oval, reddish papule, which enlarges gradually and becomes a plaque, with a red or violet border and yellowish center. The surface of the older plaques is usually traversed by fine telangiectatic vessels. The plaques are quite hard, not elevated, but the center is depressed; there is hardly any scaling. Ulceration of the center may occur. Itching or pain is never mentioned, tenderness usually being the only complaint. Patients are usually of the white race, and of wide variety of nationality. The most common age seems to lie between 10 and 40, and the majority of reported cases occurred in the female sex. Trauma appears to play a definite role in causation of this condition.

Histopathology is characterized by necrobiotic changes in collagen fibers, with loss of elastic tissue, and a peripheral perivascular inflammatory reaction involving chiefly connective tissue cells, various types of histiocytes, lymphocytes and occasional leucocytes and plasma cells. Varying amounts of lipoids are observed, usually in the center of the lesions in the region of degeneration of collagen fibers. These lipoids stain reddish brown with sudan III, and do not show double refraction with the polariscope.

The pathogenesis of this condition still remains obscure, although two hypotheses have been advanced to explain the condition. One attempts to put it on the basis of damage to the small blood vessels of the corium, by circulating toxins, with subsequent thrombosis, necrosis and secondary inhibition of fat particles. The other assumes that there is a local lipoid disturbance in the skin, based on a general disturbance of fat metabolism, which causes the cutaneous lesions. However, Hildebrand[8] and her associates found no change in the blood lipoids value in the cases they reported.

It should be possible to diagnose necrobiosis lipoidica diabeticorum on the clinical appearance of the lesions alone, and especially in a patient with diabetes mellitus. It is differentiated from diabetic xanthoma macroscopically and microscopically, and the lesions of xanthoma, unlike those of necrobiosis, disappear rapidly under proper therapy of diabetes. According to Bernstein,[9] necrobiosis can be differentiated from granuloma annulare microscopically and by the presence of sudanophilic droplets between the fibre in sections of granuloma annulare.

Necrobiosis lipoidica diabeticorum must not be

continued on next page

confused with other necrotic lesions which occur in association with diabetes. Those lesions are usually solitary, rather than bilaterally symmetrical. They are moist, rather than dry, and may be so deep as to involve the sub-cutaneous tissue. The microscopic picture differs also. Furthermore, any of those lesions will heal with proper treatment of diabetes. This is contrary to what is usually true of necrobiosis. The latter is resistant to treatment, either local or general. The lesions run an indolent, chronic course, over a period of months or years, and eventually form depressed scars. Control of diabetes with insulin and proper diet have little effect on the lesions. Klaber[10] and Kren[11] have reported good results with diets low in fat. The injection of insulin at the site of the lesions, as tried by Urbach, Zeisler and Caro, has been unsuccessful. Ultraviolet light therapy, roentgen therapy and various topical applications have been of little benefit in accelerating the healing of the lesions.

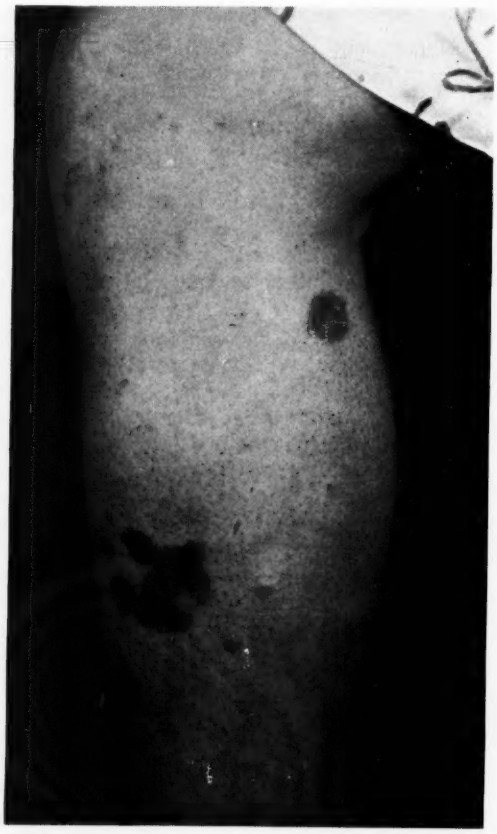

FIG. 1 Round reddish-yellowish patches, shiny, with telangectases, somewhat resembling scleroderma, located on the lower legs in a white diabetic female, are clinical characteristics of diabetic lipoidic necrobiotic dermatitis (Necrobiosis lipoidica diabeticorum Urbach).

Case Report

A white American woman, age 28, was seen at the Skin Out-Patient Department, Rhode Island Hospital in November 1947. She gave a history that in 1939 she noticed small, reddish lesions on both legs, which were slightly itchy, and at times gave a burning sensation. History revealed that she had been a diabetic since the age of 15, and was twice admitted to the hospital in diabetic coma, first in 1936 with a blood sugar level of 320 mg. per 100cc, and again in 1943 with a blood sugar level of 550 mg. per 100cc. She had received insulin therapy without interruption since the second hospital admission. Physical examination was essentially negative. The blood count was normal and Wasserman negative. Cholesterol was 390 mg. No other blood lipoids were done.

The cutaneous lesions were located on the upper and middle third of both legs. They were round, reddish in color, shiny, with a violet border, parchment-like on palpation and non-elevated. There was a slight central depression. In some lesions, fine telangiectatic vessels were noted. A biopsy taken from one of the lesions showed a histologic picture consistent with necrobiosis lipoidica diabeticorum.

Summary

Among the skin manifestations definitely related to an internal disease, one of the most conspicuous, peculiar and not too rare, is diabetic lipoidic necrobiotic dermatitis, commonly known as necrobiosis lipoidica diabeticorum Urbach. A typical case has been reported and discussed.

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SEMINAR ON EPILEPSY

The Governor's Advisory Council for the Rehabilitation and Employment of Handicapped Persons will sponsor a seminar on epilepsy to be held at the Rhode Island Medical Society Library on Wednesday, April 6, at 2:30 p.m.

Treatment facilities, education, rehabilitation and employment of epileptics will be topics discussed. Out of state speakers will be Dr. William G. Lennox, associate professor of Neurology of the Neurological Institute of the Children's Medical Center in Boston, and Dr. J. K. Merlis of the Epilepsy Center at the Cushing General Veterans Administration Hospital.

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large, multinucleated cells. The cytoplasm of these latter cells is distinct, acidophilic, or slightly basophilic. The nuclei vary from one to three in number, are vesicular, frequently indented, or folded on one side, and contain a distinct nucleolus. Fibrosis may be present. The diagnosis of Hodgkins Disease should not be made in the absence of these typical giant cells.

In the follicular type the tumor tissue forms giant primary follicles in which there is a delicate reticulum, but the greater part of the tissue is a closely packed mass of lymphoblastic cells. The architecture and sinusoids between the follicles are obliterated. The inter-follicular tissue is packed with lymphoid cells. A few mitoses are present and there is no phagocytosis.

Lymph nodes, spleen and lymphatic tissue beneath mucous membranes are the common tissues involved by malignant lymphoma, though hardly any organ is immune. Diagnosis, with certainty, can be made only on histological examination. It may be stated that any accessible lymphadenopathy that is not clearly inflammatory in origin deserves biopsy.

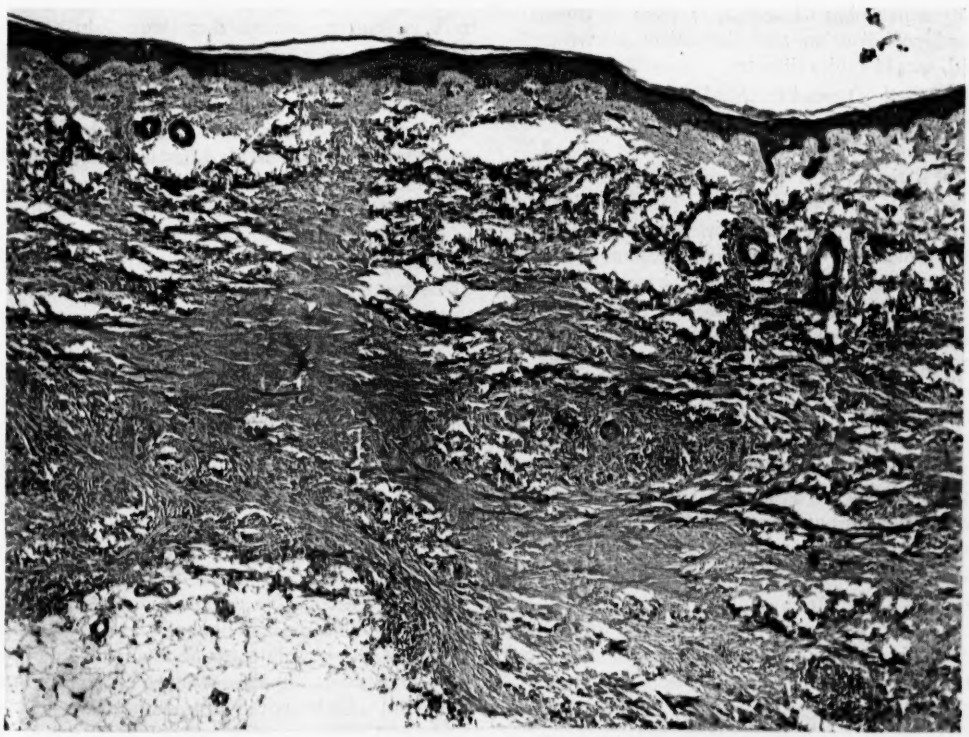

FIG. 2 **Low power photomicrograph showing areas of pseudonecrosis (collagen fibers degeneration) with lymphocytic infiltration around the same areas.**

AMA'S PLAN OF BATTLE

An Outline of Strategy and Policies in the Campaign against Compulsory Health Insurance

(Presented by Clem Whitaker & Leone Baxter, Directors of the National Education Campaign of the American Medical Association, for the Conference of State Medical Societies, Chicago, Ill., February 12, 1949)

AMERICAN MEDICINE, in its campaign against compulsory health insurance, cannot afford to fight alone.

This must be a campaign to arouse and alert the American people in every walk of life, until it generates a great public crusade and a fundamental fight for freedom.

We must make every American know that medicine is *not* simply fighting for self-interest, but is actually fighting to avert the creeping paralysis of bureaucratic regimentation of the people's lives.

We need the help of every American who honestly believes in the American way of life—and our campaign must be geared to get that help.

Any other plan of action, in view of the drift toward socialization and despotism all over the world, would invite disaster.

Doctors don't need to stand alone in this battle. They must not stand alone. And it's our job to see that they don't stand alone.

That's the reason that the American Medical Association, in establishing its National Education Campaign, has set as one of its major objectives—the mobilization of other great national organizations representing other professions, trades and businesses; civic and fraternal, religious and patriotic groups; women's clubs, farm and veterans' organizations and every other association which is willing to make common cause with medicine in this battle.

That's one of the top priority jobs we are going to be organizing and directing from the national campaign headquarters. But the success of that drive, in the final analysis, will depend on whether it reaches below the national level— down to the grass roots, in every State and county and city in America.

Let's set the record straight here today, too, on the subject of lobbying—and the smear attack that has been launched against the A.M.A. in that connection.

The charge has been made by the advocates of compulsory health insurance that the American Medical Association plans to invade Washington with a high-powered lobby and a $3,000,000 "slush fund" in an effort to block passage of the legislation in Congress.

That charge is absolutely false—and every State and county medical society, and every doctor who values the good name of medicine, should see to it that this smear attack is branded as false in every community in America.

The Washington office of the A.M.A. is one of the most modest legislative offices maintained by any of the national associations in the Capitol—and is staffed by men of unquestioned integrity, who are highly respected in Congress.

The American Medical Association isn't embarking on any high-pressure lobbying campaign in Washington, nor is there any "slush fund". The socializers in the Office of Social Security, who have used their government facilities and government funds to lobby Congress, are simply sending up a smoke-screen against A.M.A. as a cover for their own highly-questionable operations, and the people need to be told that.

The A.M.A., in its campaign, is carrying its case to the people of America in a grass roots crusade which we hope, with your help, and the help of tens of thousands of others, will reach every corner of this country.

One of the greatest rights which we have as a free people is the right of petition— and we intend to exercise that right, even though Oscar Ewing and his socializing satellites will do everything in their power to keep us from getting our story to the people. If that is lobbying, it is lobbying in the finest American tradition. The American people, not Congress, will decide this issue in the final showdown, and Mr. Ewing knows that. That's why he fears the National Education Campaign which the A.M.A. has authorized—and that's why he will do his utmost to discredit and block us.

There's another important financial policy with regard to this campaign which you should know, too—and which should be made known to every State and county medical society, as it will help to keep the record straight and let doctors know how their funds are being handled.

That policy is this:

Every dollar expended by the national campaign office will be reported in a check-by-check accounting to A.M.A. And our financial reports will be available for government inspection at any time!

That is the complete answer to the insinuations and criticisms of medicine's enemies, or political demagogues who hope to make a whipping boy of the medical profession.

Let's consider some of the other basic policies of the campaign.

The Coordinating Committee, in approving a broad, public campaign, beamed directly to the people, rather than just to Congress, established two major objectives:

The *immediate objective* is the defeat of the compulsory health insurance program in Congress—and there is great urgency in that phase of the problem. The first showdown battles on compulsory health insurance may come within the next 60 or 90 days. We can't afford to be lulled into overconfidence by reports out of Washington that no serious effort will be made to push through the program at this session of Congress. That may be propaganda emanating directly from the camp of our opponents.

The *long-term objective* is to put a permanent stop to the agitation for compulsory health insurance—and the most vital step in achieving that objective will be an all-out campaign to enroll the American people in voluntary health insurance systems. The A.M.A.'s Coordinating Committee has authorized and directed us to conduct a Nationwide educational drive to make America health insurance conscious—and to work with the pre-paid hospital plans, the pre-paid medical plans, the accident and health insurance companies and all other sound groups in the voluntary field to achieve this objective.

This is an affirmative campaign, not just a negative campaign—and I think we need to hammer home that basic point in every public appearance.

We're not just working to beat a bill. We're going to work together to resolve a problem. We're going to do something about taking the economic shock out of illness!

That's the kind of program your A.M.A. is backing—and that's the only kind of program that will eventually and finally lay the ghost of compulsory health insurance in this country.

We have already held preliminary meetings with representatives of the medical care plans and the private insurance companies to pledge them A.M.A.'s vigorous assistance in promoting voluntary health insurance—and to enlist their aid, if possible, in stepped-up selling and advertising campaigns.

I believe there are representatives in attendance here today from the medical and hospital plans and the health and accident underwriters.

In the presence of the Board of Trustees and the Coordinating Committee of the American Medical Association, I want to make this unqualified statement concerning the A.M.A.'s National Education Campaign:

The accent in this campaign is going to be on the positive. We are going to do everything in our power to acquaint the American people with the desirability and the availability of pre-paid, budget-basis medical care. We believe in voluntary health insurance, not just as a political expedient, but as a sound development in medical economics. We want everybody in the health insurance field selling insurance during the next two years as he has never sold it before—knowing that he has the prestige of the American Medical Association, and all its power and facilities, squarely behind him. And we are going to ask the doctors, when they are talking to patients in their offices, who are in need of budget-basis medicine, to take time to encourage them to enroll in a good, sound voluntary health system.

That's a fundamental part of the A.M.A. program—and I hope every representative of a State Society in this room will take that message home with him.

We have an inspiring case to present in our affirmative campaign.

More than 52 million Americans already have decided that *The Voluntary Way Is The American Way* to cope with this problem—and have enrolled in voluntary health insurance systems.

The tremendous growth of the voluntary systems has come in a very short span of years—and has been one of the most spectacular economic developments in our time.

If there was even half the demand for compulsory health insurance in this country that exists for voluntary health insurance, Oscar Ewing and the socializers would be on the road to victory and nothing could stop them.

But the major demand for compulsory health insurance in the United States is an artificial, trumped-up demand, generated by social bureaucrats. They are leaning heavily on the false lure of something-for-nothing, and the people's fear of the cost of unexpected illness, in a desperate drive to drum up public favor for their political patent medicine.

On the other hand, American medicine and the voluntary health insurance systems already are near the half-way mark in the campaign to provide pre-paid, budget-basis medicine for the American people within the normal framework of our free enterprise system.

continued on next page

The job is half done, but it is of urgent importance that it be completed. Every American who needs pre-paid medical and hospital care should know that it is available to him. We need to take health insurance out of the luxury category—and let the people know that it can be bought economically and should be included as a necessity in the home budget, just as food and shelter and life insurance are budgeted.

The finest antidote for compulsory health insurance is voluntary health insurance—and the agitation for socialization of the medical profession will come to a halt when the majority of the people have been provided with the remedy.

That's the way we can accomplish our long-term objective—and every State and county medical society in the United States ought to become a strong ally of the insurance industry and the prepayment systems, and work with them until the final objective is achieved.

Now let's take a good, hard look at our *immediate objective*—the defeat of the compulsory health insurance program in Congress.

The *time schedule* of the opening battle in Congress we can't determine. Our opponents have that advantage—and our only safe course, regardless of the conflicting and confusing reports which will emanate from Washington, is to mobilize for all-out action *now* and be ready whenever the attack comes.

Our own militancy and our own readiness for a showdown may make the socializers hesitate to force the issue at this session of Congress—and may give us badly-needed time to get our long-range campaign under full steam. But we can't have any assurance of that desired development.

The fate of other bitterly-controversial issues now pending in Congress may be a decisive factor in determining the tactics of our opponents. If other legislative proposals in the controlled-economy-program of the Truman Administration should be jammed through this Congress fairly early, we would be in real danger that the steam-roller would keep right on rolling—and in that event medicine might be engaged in a bitter battle for survival before the end of this session.

On the other hand, if Congress becomes embroiled in heated and long-drawn controversy on other issues which are ahead of compulsory health insurance on the agenda, we may have a breathing spell. Or we may find Oscar Ewing proposing a watered-down bill, hoping to disarm us with apparent moderation and get half a loaf this session with the full expectation that he will be able to get over the rest of his program later.

We can't call the shots on just how or when the battle will be joined, but we can and must get American medicine off the defensive and into an affirmative, offensive position. That's an immediate and vital necessity.

We have emphasized that this is going to be a sound, constructive campaign.

But let me *underscore* this statement:

This isn't going to be any *panty-waist* campaign!

The A.M.A. is going to wage a truthful, hard-hitting campaign, in adjective-studded language that the American people understand.

The critics of the medical profession have had their field day—and they'll continue to have it until American medicine strikes back and strikes hard.

There are going to be no punches pulled in our national publicity campaign—and we want you to know that.

We're going to Attack—and Attack—and Attack—until the truth about the vicious consequences of political medicine are known throughout this country.

We're going to put the foes of American medicine on trial before the bar of public opinion in this nation—and let the people decide for themselves whether they want *men of medicine, or medicine men,* in charge of the health of their families.

We're going to expose the shameful misrepresentation, the juggled facts and garbled statistics, the phony draft rejection figures and the deliberate attempt of Patent Medicine Man Oscar Ewing to hide from the people the true cost and the social consequences of the scheme of socialized medicine which he is proposing.

That's one of the jobs we have at the head of the list in national headquarters—and we hope that all of you, in your home States, will duplicate it.

If we're going to turn the tables on the socializers, and get the medical profession into an affirmative position, there's another immediate job to be done. That's the job of mobilizing *organization support* for medicine's cause in agriculture, in business, in industry, in the veterans' organizations, in the women's clubs, in churches and lodges—and in all the thousands of organizations which make up a cross-section of America.

The fastest way to make our influence felt in Washington is to marshal a powerful array of Nation-wide organizations, representing great groups of American citizens, in opposition to compulsory health insurance.

That job is the direct responsibility of our national headquarters and the drive for specific action by hundreds of national organizations, trades and professions already has started. But we'll need lots of help from all of you in making this phase of the campaign successful.

In moving for important endorsements of medicine's position, medical leaders who have the con-

tacts often will be called on to help open the door or close the sale.

From these major endorsements will stem much of our publicity in the early days of the campaign, designed to broaden the campaign into a great public crusade. We need allies, strong allies, whom we can convince that this is their battle just as much as ours. We need the use of their mailing facilities, space in their newsletters, house organs and magazines. We need letters and phone calls and telegrams from their members, flowing to their Congressmen.

All of this requires manpower. Our small professional staff can't possibly do all the work, but we believe that we can find doctors and others who will do it. Mainly, this is the same task which confronts military organization. The troops fight the battle, but they first have to be properly mobilized, trained and directed.

In every State and in every county there should be similar organization drives—for action by State and local organizations which help to mould public opinion. We need the impact of their support on your Congressmen—and your United States Senators. We want them to hear from the organizations at home, so that they know how their own constituents feel on this issue.

Miss Baxter, the more practical member of our team, who always insists on nailing down the specifics, will tell you in her presentation what you can expect from the national headquarters—and what we would like to expect from you.

Let me say this to you in that connection:

One of the objectives of the national headquarters will be to provide you with all the materials of war—and to lighten the financial load on the State and county societies. We will attempt to provide you with pamphlets and posters, form speeches, cartoons, mats and other supplies in any quantity you can put to good use. We hope the only limit that will be placed on the materials available to you will be the limit of your ability to get them into the hands of voters in your home States and communities.

The question has been asked whether the A.M.A. will also allocate funds to the States to help in distribution costs, or for other purposes. The answer to that question is "No", for reasons which probably require no explanation.

I want to touch briefly on another probable development in the national campaign which is still in the evolutionary process, but which you will hear about in more detail within the near future.

We have recommended that a national committee of leading citizens in all walks of life be established as auspices for an important part of the work in this campaign—a committee which we will help to organize, but which will also draw strength from many other sources.

This organization will be called the...

AMERICAN COMMITTEE
FOR HEALTH SECURITY

Under the Committee's name, on one side of the letterhead, will be the slogan: "For Voluntary Health Insurance; Against Compulsion!" On the other side, balancing this, will be a second slogan: "The Voluntary Way Is The American Way."

Some of the great, outstanding leaders of America have agreed to serve as members of this national lay committee—and we believe it will broaden our front and create a rallying place for thousands of people who have no direct connection with medicine, but who have a healthy interest in the welfare of America.

When the time comes for perfecting that organization, we may ask each of you to help recruit some of the outstanding lay leaders in your State for that Committee.

Now let's return to the most important man in this campaign—the practicing physician!

The 150,000 members of the American Medical Association must be the front line troops in this battle.

The A.M.A. and the State and county medical societies can't win this fight, but their members can.

A doctor can talk to his patients on this issue and get their earnest attention, because this is an issue that involves their health and their relationship with the doctor.

Our greatest need—and this is the most important job you will have—is to get the word to every doctor that this is an emergency, that his help is needed, and that his right to continue in private practice may depend on how he measures up to the challenge.

We need every doctor on fire on this issue... taking time out to talk to every leader he knows in the community, urging them to write their congressmen, stirring his patients and friends into action.

A doctor knows that political medicine is bad medicine—that it means hit-or-miss diagnosis and superficial treatment of symptoms. He knows that personal interest in the welfare of the patient suffers when assembly-line medical practice takes over. And he knows that the quality of medical care steadily deteriorates when doctors succeed or fail on the basis of political preferment, or on the number of cases they can rush through their offices in a crowded day.

No one can talk to a patient on that subject with the eloquence of his family doctor—and we simply must have that doctor at work, if this battle is to be won.

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PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION FOR THE ADVANCEMENT OF MEDICINE AND PUBLIC HEALTH

A Federal Department of Health

1. Creation of a Federal Department of Health of Cabinet status with a Secretary who is a Doctor of Medicine, and the coordination and integration of all Federal health activities under this Department, except for the military activities of the medical services of the armed forces.

Medical Research

2. Promotion of medical research through a National Science Foundation with grants to private institutions which have facilities and personnel sufficient to carry on qualified research.

Voluntary Insurance

3. Further development and wider coverage by voluntary hospital and medical care plans to meet the costs of illness, with extension as rapidly as possible into rural areas. Aid through the states to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans with local administration and local determination of needs.

Medical Care Authority with Consumer Representation

4. Establishment in each state of a medical care authority to receive and administer funds with proper representation of medical and consumer interest.

New Facilities

5. Encouragement of prompt development of diagnostic facilities, health centers and hospital services, locally originated, for rural and other areas in which the need can be shown and with local administration and control as provided by the National Hospital Survey and Construction Act or by suitable private agencies.

Public Health

6. Establishment of local public health units and services and incorporation in health centers and local public health units of such services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health laboratory services. Remuneration of health officials commensurate with their responsibility.

Mental Hygiene

7. The development of a program of mental hygiene with aid to mental hygiene clinics in suitable areas.

Health Education

8. Health education programs administered through suitable state and local health and medical agencies to inform the people of the available facilities and of their own responsibilities in health care.

Chronic Diseases and the Aged

9. Provision of facilities for care and rehabilitation of the aged and those with chronic disease and various other groups not covered by existing proposals.

Veterans' Medical Care

10. Integration of veterans' medical care and hospital facilities with other medical care and hospital programs and with the maintenance of high standards of medical care, including care of the veteran in his own community by a physician of his own choice.

Industrial Medicine

11. Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highway, home and on the farm.

Medical Education and Personnel

12. Adequate support with funds free from political control, domination and regulation of the medical, dental and nursing schools and other institutions necessary for the training of specialized personnel required in the provision and distribution of medical care.

The RHODE ISLAND MEDICAL JOURNAL

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CHILDHOOD MORTALITY FROM RHEUMATIC FEVER

A REPORT by Dr. George Wolff, issued by the Federal Security Administration, presents interesting facts concerning childhood mortality from rheumatic fever and heart disease. Such a report based on the accuracy of the death certificate as is done in the study of mortality from other diseases, emphasizes the importance of the obligation of all physicians in making death returns.

Rheumatic fever plus heart disease has become, outside of deaths from accidents which leads all others in causes of death in childhood, the chief cause of death for all boys and girls between the ages of 10 to 14 years, and in white boys in the 15 to 19 age group. In the 5 to 9 age group (again omitting deaths from accidents) in white children, pneumonia or influenza ranks first and appendicitis second, while rheumatic fever and heart disease fall into third place. The lower rate in this group is probably due to the fact that even though the incidence of the disease may be high in this age group the children do not succumb until after several recurrences when they reach the 10 to 15 year age group.

In the non-white group of children from 5 to 9 years pneumonia and influenza holds first place while tuberculosis ranks second with rheumatic fever and heart disease again third. It is well to note the importance of tuberculosis in this non-white group. Further, while rheumatic fever leads in the 15 to 19 group of white children as noted above, in the non-whites of this age group tuberculosis holds first place, homicide, pneumonia and rheumatic heart disease follow in that order. Yet in the total number of deaths rheumatic fever and heart disease is greater in the non-white group than in the whites of this 15 to 19 age group. When one couples this with the mortality from tuberculosis and homicide in the non-white group the contention might seem well-founded that rheumatic fever should be classified under those diseases that are aggravated by adverse socio-economic conditions. It is indeed a sad commentary upon the lack of social, economic and medical advantages which this group sorely needs.

Geographically the report points out that the northeast, particularly the middle Atlantic States, leads in mortality from rheumatic fever. The mountain states follow closely, while in the South, even though non-whites present a national mortality rate higher than that for the white population, the death rate is low, as is also true in the Pacific Coast States.

How can this geographical mortality be explained by other than what we know to be true, the com-

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municability of rheumatic fever? Climatic conditions would seem not to be important, for the high mountain states and the Middle Atlantic States have entirely different climates. Yet these two sections have the greatest incidence of rheumatic fever. There is also the vast difference in the climates of the south and the Pacific Coast States which have the lowest incidence. It is to be noted that Dr. Wolff suggests that the rate in the high mountain states may be due to the poor socio-economic conditions of the children of Mexican origin inhabiting these states.

It is gratifying to observe that the mortality rate from rheumatic fever and heart disease has decreased in the white population in the last decades. There seems however to be an increase in the non-white population. The disease once established in this group seems to spread more rapidly.

The implications in this report, if one reads between the lines, are:

1. The responsibility this country must assume to reduce the deaths from accidents which lead all others.
2. The importance of educating more non-white physicians to minister to the medical cares of their race. Medical schools should be opened to them and they should have internships in our major hospitals. If the Federal Government would offer a plan to aid such special groups it is doubtful that there would be anything but a whole-hearted willingness on the part of the medical profession to assist in such a movement.
3. That we continue to emphasize the importance of rheumatic fever and heart disease as a cause of death. That medical school examinations be made in the presence of parents in order for the physician through a good history to make a more thorough appraisal of the child's health. That we encourage school teachers to become more health-minded that they may make observations upon their pupils which will be of value to the school physician. That although many children are referred to physicians because of symptoms which make a parent suspicious, yet they do not have rheumatic fever, it is wiser for parents to ask for an examination. Occasionally we do find an early case of rheumatic fever in these children. That the continued education of the parent must be considered of paramount importance.

MEDICAL-DENTAL RELATIONS

The Rhode Island Dental Society is a live organization, as one could have had demonstrated to him by attending the annual meeting in January. Perhaps some of this is due to the snappy young men they have for presidents. Dr. McKivergan, the retiring president, is still waiting for his hair to turn color. Our presidents in the Medical Society have a decided tendency to carry more of the dignity of years when they are in office. We say this despite the occasional exception of such young and vigorous presidents as we occasionally have, like Dr. Gormly or Dr. Kenney.

The moving spirits of the Dental Society are showing a lot of enthusiasm in the re-adjustment of medico-dental relations. As most of you know, there was a joint committee from the Rhode Island Medical Society and the Rhode Island State Dental Society which considered this matter and issued a report last June. The teeth and jaws are, of course, as integral a part of our anatomical and physiological makeup as are any other part of the body, yet there has been a separate and distinct profession to take care of them. Every urologist, every ophthalmologist, every ear, nose and throat practitioner is first of all a doctor of medicine. With rare exception the dental men are not. The mechanical part of dentistry is so great that perhaps we may never expect that all dentists will be doctors of medicine. Nevertheless, it has been more and more appreciated that they should not remain apart from us entirely. We suppose that nearly all dental schools are affiliated with medical schools so that the early basic training is the same for both groups of students. After graduation the two groups drift apart. It probably is a rare dental man who has a reasonably comprehensive knowledge of medicine, and it is safe to say that few medical men have more than the most elemental knowledge of the teeth and jaws.

Our two Societies are trying to change this, particularly as regards what comes after graduation. The number of dental internships and residencies are increasing. The scope of these men's work is also being extended.

Hospital relationships for those in private dental practice are also increasing. Rhode Island, it seems to us, is particularly fortunate in this respect. The Samuels Dental Clinic is an organic part of the Rhode Island Hospital. It is connected with the outpatient department of the Hospital. Under the leadership of Dr. Wisan more and more dental cases are being referred to the various outpatient departments for special health examinations, and this and other departments are calling the Samuels Clinic for more help.

At this recent meeting of the State Dental Society there was an interesting and valuable medico-dental symposium participated in by several dental men

from large nationally-known clinics, and by local physicians and dentists. We are sure that the large group that listened intently to this discussion found it illuminating and were made enthusiastic regarding the value of these inter-relationships.

It is pertinent to quote here a set of principles that were accepted by the Research Committee of the American College of Dentists and which were included in the aforementioned report of the joint committee of our societies.

General

1. Dentistry, in service to the patient, should be made fully equivalent to an oral specialty of medical practice.

2. Complete autonomy for each profession is desirable and necessary. For both, there should be independence with interdependence—a true perspective for each and an effective coordination of both in all individual relationships.

3. Intimate cooperation between the dental and medical professions is essential for the promotion of the public welfare.

Educational

1. Universities should give to each division of knowledge and of public service the attention required by its relationships to public welfare.

2. Medical education and dental education have a common foundation in the basic sciences and, in universities, should be so coordinated as to enable each division to meet fully its obligations in the training of professional personnel.

3. Dental students should be given a better medical understanding, and medical students a better dental understanding.

4. Medical and dental students in universities should be admitted and taught under conditions that would afford opportunity for social and scholastic equality.

5. Clear distinction between training for general practice and for further special practice, with adequate provision for graduate work in special practice, teaching and research, is essential for the full development of each profession's health service.

6. Close geographic and intellectual relations of dental and medical schools with hospitals, for teaching, research and service, are essential.

Professional

1. Dentistry's professional opportunities should be equalized, in quality with those of medicine, in educational and scientific advancement, in attention to the health of the patient and in public recognition for successful health service.

2. Conditions should be made favorable everywhere for close collaboration of individual medical and dental practitioners in service for their patients.

3. No general hospital is complete in its health service personnel without adequate dental staffs and dental internships as well as dental instruction for medical students.

4. Systematic plans of management of oral surgical service as an integral part of hospital administration should be put into operation in all general hospitals.

Civic

1. Dentistry, as a part of a complete health service, should be included in all health service centers, to cooperate closely with medicine; and also should be represented in national, state and municipal health commissions.

Dr. Midgley, who is the chairman of the Committee on Dental Research of the American College of Dentists, is spearheading a move of the Rhode Island State Dental Society for the initiation of a course of instruction under university control for medical and dental practitioners. The department of medical sciences at Brown University headed by Professor Charles A. McDonald is cooperating by holding a seminar this spring. We give in this Journal a program of these talks. The six men contributing lectures to this seminar are of national and even international reputation. Dr. Midgley says, "This activity is also of historic interest for it is the first time to our knowledge that all the essayists on a dental study program are to be members of medical school faculties and under the patronage of an academic institution that has neither a medical nor a dental school."

The Rhode Island State Dental Society is to be congratulated for its progressive leadership in seeking a better understanding between dentists and physicians in the practice of the healing art. The department of medical sciences at Brown University makes a notable contribution to the cause by co-sponsoring the seminars starting this month. Out of such programs may well develop a national program of inestimable value to the Professions.

MEDICAL-DENTAL SEMINARS

TO BE HELD at Manning Hall, Brown University, at 7:30 p.m. under the auspices of the Rhode Island State Dental Society and the Department of Medical Sciences of Brown University.

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March 22

"FOCAL INFECTION IN THE ETIOLOGY OF DISEASE"—John A. Kolmer, M.D., Professor of Medicine, Temple University School of Medicine and Dentistry; Director, Research Institute of Cutaneous Medicine.

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March 29

"ORAL MANIFESTATIONS OF BLOOD DYSCRASIAS" — William B. Castle, M.D., Utrecht Professor of Medicine, Harvard University, Director, Thorndike Memorial Laboratory, Director, Second and Fourth Medical Services (Harvard) Boston City Hospital.

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April 5

"NUTRITION IN DENTAL MEDICINE" — James H. Shaw, Ph.D., Associate in Nutrition—Harvard School of Dental Medicine: Assistant Professor in Dental Medicine, Harvard School of Dental Medicine.

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April 12

"HEART DISEASE"—Paul Dudley White, M.D., Clinical Professor of Medicine, Harvard University, Executive Director, National Advisory Heart Council, Chief Advisor, National Heart Institute.

* * * * *

April 19

"THE INFLUENCE OF HEALTH AND DISEASE ON THE GROWING CHILD"— R. Cannon Eley, M.D., Associate in Pediatrics and Communicable Diseases, Harvard University Medical School, Chief of Isolation Service and Visiting Physician, Infants and Children's Hospital, Boston.

* * * * *

April 26

"DIAGNOSIS AND TREATMENT OF ORAL TUMORS"—Malvin F. White, M.D., Professor, Oral and Facial Surgery, Tufts College Dental School, Assistant Professor, Surgery (Plastic Surgery) Tufts College Medical School.

The Second Annual

DR. ISAAC GERBER

Oration

Sponsored by the Staff of Miriam Hospital

WEDNESDAY, MARCH 30,

at the Medical Library, 8:30 P.M.

"RECENT DEVELOPMENTS IN THE MANAGEMENT OF THE FAILING HEART"

HARRY GOLD, M.D.

Professor of Clinical Pharmacology, Cornell University Medical College

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AMA'S PLAN OF BATTLE

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Doctors know, too, if they are familiar with what's happened in other countries, that invasion of the individual's privacy is one of the most objectionable features of compulsory health insurance. They know that the sanctity of the physician-patient relationship goes out the window when government medicine comes in.

That's a subject on which a doctor can talk convincingly—and our campaign pamphlets will provide corroborative material on that personal, compelling issue.

People talk to doctors about their financial troubles as well as their physical ills—and they'll listen to the doctor if he tells them that compulsory health insurance isn't *free*—that, instead, it will mean a 6 or 8 per cent payroll tax on every dollar they earn.

That's the kind of missionary work that will win this campaign—and that, more than all else, will give us a real grass roots campaign.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on January 19, 1949

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, January 19, 1949. The meeting was called to order by President Joseph C. O'Connell at 8:15 p.m. Delegates in attendance were:

Kent
Rocco Abbate, M.D.
Peter Erinakes, M.D.

Newport
James Callahan, M.D.

Pawtucket
Charles L. Farrell, M.D.
Henry Hanley, M.D.
Robert Henry, M.D.
Earl Mara, M.D.

Providence
Charles J. Ashworth, M.D.
Robert Baldridge, M.D.
Philip Batchelder, M.D.
J. Murray Beardsley, M.D.
Alex M. Burgess, M.D.
E. Victor Conrad, M.D.
Paul C. Cook, M.D.
Morgan Cutts, M.D.
Frank Cutts, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
John A. Dillon, M.D.

Providence continued
William J. H. Fischer, M.D.
David Freedman, M.D.
Peter F. Harrington, M.D.
William Horan, M.D.
Russell R. Hunt, M.D.
Herman P. Grossman, M.D.
Albert H. Jackvony, M.D.
Louis I. Kramer, M.D.
Robert G. Murphy, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Michael J. O'Connor, M.D.
Louis A. Sage, M.D.
Daniel V. Troppoli, M.D.
George W. Waterman, M.D.
Frederick A. Webster, M.D.

Washington
Louis Morrone, M.D.

Woonsocket
Henri Gauthier, M.D.
Victor Monti, M.D.

Also in attendance were Dr. Roland Hammond, Chairman of the Committee on Medical Defense and Grievance, and Dr. Stanley Sprague, Chairman of the Committee on Industrial Health, Mr. Charles Williamson, Legal Counsel and Mr. John E. Farrell, Executive Secretary.

REPORT OF THE SECRETARY

The Council has held two meetings since the House of Delegates last met. Among some of the important actions taken, in addition to special recommendations to the House, were:

Fees for Insurance Examinations

The Council considered several problems relative to the ruling of the House regarding fees for physical examinations for insurance companies. The Council has requested the Committee on Medical Economics to review the problem, and to report to the House of Delegates.

Endowment Fund Stock

With the absorption of the Bank of Commerce by the Hospital Trust Company the stock, 16 shares of which the Society held, was called in by the Trust Company. The Council authorized the Treasurer to sell this stock credited to the Endowment Fund, and to invest the money received in United States Government bonds. This transaction has been completed.

Costs of Medical Care

The Council has requested the Executive Secretary to investigate and report to it on ways and means to make a study of the rising cost of hospital and other health care in Rhode Island as compared to the cost of physicians' services.

Use of Library Building

The Council requested the Board of Trustees to permit the Rhode Island Cancer Society to use the basement room of the Library one night each week for the conduction of speech class for persons who have undergone a laryngectomy.

Selective Service Advisory Committee

The Council has authorized the President of the Society to appoint an advisory committee to the state director of Selective Service of Rhode Island in accordance with a request from that organization. Such a committee would advise the Selective Service Director as to the needs of the various hospitals and counties of the state.

Public Relations Officer

Requested by the Committee on Public Relations of the Society to consider the possibility of a public relations officer as a member of the employed staff of the Society, the Council authorized the President to name a committee to explore the financial aspects involved in the employment of a public relations officer for the Society to serve as an assistant to the Executive Secretary.

COMMUNICATIONS

The Secretary read a communication from the Division of Professional Regulation of the State Department of Health reporting that the Rhode

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HOUSE OF DELEGATES

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Island Board of Examiners in Medicine had amended its regulations to exclude from licensure any person who matriculated at a foreign medical school subsequent to January 1, 1949. The action of the Board of Examiners in Medicine was briefly discussed. No action was taken by the House of Delegates.

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Dr. O'Connell reported that Dr. Peter Pineo Chase, Delegate of the Society to the American Medical Association meeting in St. Louis in December, 1948, was ill and unable to report to the House at this time.

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE AND GRIEVANCE

Dr. Roland Hammond, Chairman of the Committee on Medical Defense and Grievance requested that the House go into Executive Session to hear his report. The motion was made, seconded and adopted that the House sit in Executive session for the hearing of this report. Dr. Burgess moved that the House of Delegates accept and approve the oral report presented by the Chairman of the Committee on Medical Defense and Grievance, and he further moved that the physicians involved in the two cases brought before the Committee be notified that the House of Delegates supports the action taken by the Committee in their cases. The motion was seconded and adopted.

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

Dr. Stanley Sprague, Chairman of the Committee on Industrial Health reported how he had met with Governor Pastore to discuss medical phases of the Workmen's Compensation Act. He stated that he had asked the Governor to arrange a meeting with the Workmen's Compensation Commission, whose term of service expired with the adjournment of the General Assembly in 1948, to discuss improvements in the Workmen's Compensation Act. He stated that he understood no amendments to the Law or new Law is now being drafted. He inquired whether the House of Delegates felt that the Committee on Industrial Health should propose amendments. He also raised the question of the differential in office charges of physicians in Massachusetts and Rhode Island, and inquired whether there should be an official office fee in Rhode Island.

Dr. Troppoli moved that the Rhode Island Medical Society establish as the official minimum office fee to be charged in all Workmen's Compensation cases to be $5 for the first visit and $3 for subsequent visits. The motion was seconded.

There was discussion of the motion with Dr. William P. Davis expressing the opinion that the matter should not be settled immediately but that the whole problem should be explored by the committee. Dr. Horan supported this opinion. Drs. Sprague, Morrone, Farrell and Grossman discussed the question further before Dr. O'Connell called for the vote. The motion was adopted.

Dr. Sprague asked what action the House wished to take regarding amendments to the act and he outlined some of the problems that had arisen in the discussion of improving the Workmen's Compensation Law.

Dr. Harrington expressed the opinion that the committee is free to draw up a law and submit it. Dr. Sprague stated that legal help and advice would be needed. Dr. O'Connell stated that the Committee on Industrial Health was free to call upon the services of the Legal Counsel of the Society in this matter.

RECOMMENDATIONS FROM THE COUNCIL

The Secretary reported the following recommendations from the Council of the Society:

1. *Delegate to the American Medical Association for 1949 and 1950.*

The Council nominates Dr. Charles L. Farrell, of Pawtucket, as Delegate, and Dr. Charles J. Ashworth, of Providence, as Alternate Delegate, to the House of Delegates of the American Medical Association for the years 1949 and 1950. The motion was unanimously adopted by the House of Delegates.

* * * *

2. *Nominees for Election as Blue Cross Directors:*

The Council nominates for candidates for election as members of the Board of Directors of the Hospital Service Corporation the following:

William P. Davis, M.D. Samuel Adelson, M.D.
G. Raymond Fox, M.D. Philip Batchelder, M.D.
Albert H. Jackvony, M.D. Edward S. Brackett, M.D.
E. Victor Conrad, M.D.

After discussion by the House of the assignments for these directors as representatives of the Society, since the Blue Cross is not an active participant in the surgical plan, Dr. Abbate moved that although the doctors have not functioned for the Society, and cannot function until the Blue Cross accepts the surgical program, and in view of the fact that negotiations are now beginning with Blue Cross, that the House of Delegates elect the seven candidates nominated by the Council to serve as members of the Board of Directors of Blue Cross for 1949. The motion was seconded and adopted.

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3. *AMA Assessment*

The Council recommends that the $25 assessment by the American Medical Association on its members be collected in Rhode Island by the Rhode Island Medical Society and transmitted to the American Medical Association.

It is also recommended that the President of the Rhode Island Medical Society be authorized to send an explanatory letter to each member at the time of the billing for the assessment, urging support of the American Medical Association.

Discussion

Dr. Mara suggested that the billing and collection might be done by the district medical societies who would be in a better position to influence their members to support the assessment. Dr. Ashworth, treasurer of the Society, stated that the Council would be glad to have each district society accept the responsibility of collecting the assessment. Dr. Burgess asked Dr. Farrell to explain the purposes of the assessment.

Dr. Farrell reported that it was a fund for the education of the public to the danger inherent in a federal program for the control of medicine. He reported that the fund would be under scrutiny by the profession and the public and that its use would be only for the advancement of medicine for the people of this country. He reviewed the position of the American Medical Association in the matter and he reported regarding the functions of its Washington office. After quoting from a letter from Dr. Lull regarding the assessment he urged that every member of the Society support the assessment.

Dr. O'Connell called for a vote on the question. The motion as presented was adopted.

* * * *

4. *By-Law Interpretation*

The Council recommends that the House of Delegates go on record as interpreting Sections 9 and 10 of Article IV of the Society's By-Laws to mean "district" society where the wording is "county" society when these sections of the By-Laws are applied to problems arising within the district societies within Providence County.

Dr. Abbate moved that the House of Delegates adopt the recommendation. The motion was seconded and adopted.

REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

Dr. William P. Davis stated that the report of the Committee on Medical Economics had been prepared and distributed in advance to each member of the House and therefore he would not read it. (This report is appended to and made a part of the official minutes of this meeting.)

He called specific attention to the recommendations on page three of the report.

Discussion

Dr. Morrone stated that the Washington County Medical Society had voted not to accept fees less than those established by the Society. Dr. Harrington expressed the opinion that the insurance industry depends in great measure on the health examinations conducted by physicians for them. He expressed the opinion that the fees paid are not high enough.

Dr. Harrington moved that the report of the Committee be accepted. The motion was seconded and adopted.

The Executive Secretary reviewed the entire question from both the national and local viewpoint. Dr. Dillon moved that a printed notice of the definite policy of the Society regarding fees for health examinations for an insurance company be available at the headquarters of the Society for use by physicians desiring them, and further, that each member of the Society should receive a copy of this form with an explanation that it should be sent with his bill to the insurance company and that he can get additional copies from the Society. The motion was seconded and adopted.

REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

Dr. Charles L. Farrell briefly reviewed the work of the Public Relations Committee, relating its conferences with the editors of the Providence Journal-Bulletin, and its efforts to improve public relations in Rhode Island. He also reported of the proposed public relations program being drafted by the American Medical Association.

He expressed the strong belief that in view of the fact that the personnel of the committee changes from time to time that there should be a designated employee of the Society who would work under the direction of the Executive Secretary to assist in the publication of news releases and in general public relations matters. The report of the Public Relations Committee was accepted as presented.

REPORT OF THE HEALTH INSURANCE COMMITTEE

Dr. Rocco Abbate read the report of the Health Insurance Committee, a copy of which was distributed to each member of the House of Delegates. This report is made a part of the official minutes of this meeting.

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BIBLIOGRAPHY: 1. McGuire, W. P.: Virginia M. Monthly 75:338, 1948. 2. Uhde, G. I.: Am. J. Ophth. 31:323, 1948.

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At the conclusion of the reading of his report Dr. Abbate moved the adoption of the report together with the recommendations incorporated in it. The motion was seconded.

Discussion

Dr. Frank Cutts inquired whether there were any medical society plans with a single corporation. Dr. Abbate informed him there were only four plans operating with a single Blue Cross—Blue Shield Corporation, but all of these plans were indemnity plans and did not incorporate the service feature that is in the Rhode Island Plan.

Dr. O'Connell called for a vote on the motion. The motion was adopted.

RESOLUTION REGARDING DISPLACED PHYSICIANS

Dr. Alex M. Burgess introduced the following resolution which, if adopted, would be presented to the House of Delegates of the American Medical Association:

WHEREAS it is generally admitted that there is a need for more qualified physicians than are now available in this country and

WHEREAS there is at present a large group of physicians who, with their countrymen, have been rendered homeless and are now living as displaced persons under the care of the International Refugee Organization in Western Germany and elsewhere and

WHEREAS many of the physicians are known to be highly trained specialists and practitioners and

WHEREAS many of these physicians have entered and many more will be resettled throughout the civilized world including the United States

THEREFORE BE IT RESOLVED that a special committee on Displaced Physicians be appointed by the President of the American Medical Association, to consist of six members, whose duty it shall be to study the problems of Displaced Physicians generally and as far as possible to cooperate with the International Refugee Organization and the various state authorities in furthering the resettlement of these individuals in a spirit of friendly cooperation with unfortunate colleagues.

Discussion

Dr. Abbate inquired how many physicians were estimated to be displaced in the German area. Dr. Burgess replied that in July, 1948, there were approximately 2,500 such physicians who cannot return to their own countries because of political reasons. They are not licensed to practice in Germany and are presently caring for displaced persons who are being resettled.

Dr. Morrone and Dr. Erinakes supported the resolution. Dr. Burgess pointed out that in offering the resolution he did not visualize that the Committee proposed by it would bring physicians to this country. It would merely help to adjust those who do come to the United States.

Dr. Burgess moved the adoption of the resolution. The motion was seconded and adopted.

BENEVOLENCE FUND

Dr. David Freedman presented the question of a Benevolence Fund to be established by the Rhode Island Medical Society as a possible means of aiding physicians who may become incapacitated physically and unable to carry on the practice of medicine either temporarily of permanently.

He definitely stated he had in mind a Benevolence Fund and not a Health and Accident Fund. He moved that the President be authorized by the House of Delegates to appoint a committee of five to study the advisability of a Benevolence Fund of the Rhode Island Medical Society to aid members of the Society. The motion was seconded and adopted.

* * * *

The meeting adjourned at 11:20 p. m.

Respectfully submitted,

MORGAN CUTTS, M.D.
Secretary

HEALTH INSURANCE COMMITTEE
of the
RHODE ISLAND MEDICAL SOCIETY

Report to the House of Delegates, January 19, 1949

IN SEPTEMBER the Health Insurance Committee pointed out in its report to the House of Delegates that the development of the surgical insurance plan had been, and would necessarily be slow. Several factors have mitigated against the sale of the policy. Briefly, these are:

1. In union-organized shops bargaining is a major factor in providing for social security benefits for workers. Most union contracts are on a time basis, and many such contracts do not expire until this year and 1950.
2. Management, anticipating renegotiation by labor leaders relative to wage contracts this year has been reluctant to assume any additional expenses for social security benefits until it is determined whether such benefits will be made a part of the wage agreement. The Inland Steel decision making social security benefits allowable as part of a wage agreement has also been a factor of concern to management.
3. There are more than 50,000 employees with surgical insurance protection now in Rhode Island as the result of group liability insurance policies sold by private insurance companies. This coverage is apparently adequate, and at present management is not changing over to the Rhode Island Plan where policies are now in force.
4. The weekly wage average for workers has risen considerably since the income limits were established under the Rhode Island Plan three years ago. As a result management and labor do not feel that the income limits of our Plan are sufficient to make the policy attractive to them at this time.
5. There are restrictive provisions in the Rhode Island Plan, such as the unearned income being computed as part of the total income in estimating the income level, and also the inclusion of dependents' income in figuring the gross income, that are not only administratively difficult to compute, but are also objected to by potential subscribers.

The Health Insurance Committee has worked on the theory that the Rhode Island Plan should be improved as experience warranted. For that reason it makes recommendations to the House of Delegates at this time that it believes worthy of acceptance by the Society. These recommendations are as follows:

1. That the income limits for subscribers to the Plan shall be determined solely on the basis of annual wages, and provided further that the service features of the Plan be extended to include individual subscribers with an annual income of $2,400, an individual and one dependent, $3,000, and an individual with two or more dependents, $3,600.

(Note: Adoption of this recommendation would eliminate from the Plan the requirement that the "unearned income" and the "aggregate family" income would be included in computing eligibility for service benefits under the Plan.)

2. That the present Master Schedule of Surgical Indemnities be retained.

* * * *

Experience has shown that the income limits set by the Committee more than two years ago, and adopted by the Society, are not in line with today's wage levels. When the Committee established its limits of $2,000 for the individual and $3,000 for the family it was with knowledge of the average weekly wage of workers in the State at that time. In the intervening period wages have risen, and consequently have limited the number of persons who are eligible under our Plan for service benefits.

The Committee has explored the possibility of a second policy whereby persons in a higher income group, possibly to a $5,000 income level, might be insured for a proportionately higher premium for which a proportionately higher schedule of indemnities might be paid. This suggestion encountered two serious objections:

(1) it would present difficult administrative problems in selling to groups

(2) it might create an unwarranted impression among policy subscribers that the surgical service given those in the higher income group, for whom the indemnity would be greater, would be better.

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HEALTH INSURANCE COMMITTEE

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After exploring the matter carefully, and with consideration of developments in other States, the Committee recommends that the present income limits be increased as previously stated. All service type of plans with which we are familiar establish the income level on the basis of the gross annual salary of the wage earner, and therefore we feel that our Plan should adopt a similar procedure.

BLUE CROSS PARTICIPATION

The Committee on Health Insurance has always felt that the Blue Cross should be eligible to participate in the Plan in spite of the difficulties encountered by the Society in previous negotiations seeking the cooperation of that organization. The Plan definitely provides for Blue Cross participation.

With the adoption of the Rhode Island Plan by the House of Delegates a year ago, a formal invitation was extended by the Committee to the Blue Cross to participate. In March, 1948, the Committee was notified by Blue Cross that its executive committee had considered the invitation but regretted that it could not accept. The one remaining obstacle cited to such participation was that a solution has not been found by Blue Cross relative to pro rata payment to physicians if funds should at any time prove inadequate to pay scheduled fees in full as required by the Plan.

In anticipation of this meeting of the House of Delegates, the Committee invited representatives of the Blue Cross to meet informally to explore the possibility of adoption of a solution of this obstacle cited above as evolved by the Committee. A formal meeting was requested by Blue Cross, and it was held a week ago. At that time the Committee made the following statements:

> As presently constituted Blue Cross is a Hospital Service Corporation designed to assist in the cost of hospital service. The Rhode Island Medical Society does not believe that a single corporation can effectively administer both a hospital and a surgical plan because of the different service given, the different participants, and the different policies that must be formulated. Nowhere in the country is there a statewide surgical plan approved by a medical society and offering service benefits for a stated income group that is handled by a single corporation.
>
> On the contrary, the various state plans have successfully operated *with* separate corporations, governing bodies and contracts, and with the Blue Cross Hospital Service Plan handling only the enrollment and some business procedures. Where the work has been too much for the single director, it has been divided with no difficulty and with no disruption of management.

* * * *

The Committee has sought a solution to the problem of Blue Cross participation in Rhode Island and it offered the following proposal:

> "That a nonprofit medical service corporation in accordance with the Rhode Island laws be formed by the Rhode Island Medical Society which would provide for a governing body of physicians and laymen, a majority of whom would be selected by the Society. This Medical Service Corporation would establish contracts and programs of procedure for a surgical and a medical insurance plan, the enrollment and business procedures of which would be handled by the Blue Cross Hospitalization Service Plan. For its services the Blue Cross would be compensated by the Medical Service Corporation."

The Blue Cross representatives did not reject this proposal, but they did counter with a proposal of their own that there be a single corporation, the existing one, whose authority would be divided as regards the surgical and the hospital plans, but which would meet as a single body on general procedures for both plans.

As a further requirement for participation under either a single or separate corporation Blue Cross would demand that the Rhode Island Medical Society withdraw its endorsement of private insurance policies.

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The ramifications of the counter proposal of the Blue Cross for a single corporation will require detailed study before your Committee can present the matter clearly to the House of Delegates. We are of the belief that separate corporations as exist in 28 other state medical plans would be the better arrangement because it would place the responibility for payment of claims, possibly involving at the beginning pro rata payments to physicians, with the Medical Service Corporation which would be in a position, if necessary, to request such cooperation from physicians.

We have pointed out to the Blue Cross that throughout the country surgical insurance plans embodying the service feature operate through a corporation the policies of which are controlled by physicians. This is not an accidental development. A surgical plan does not contemplate payment of hospital bills. It provides for direct payment to physicians for surgical procedures done in the doctor's office, in homes, or in hospitals. The physicians offering their services, and accepting if necessary a reduction in fees, are not like hospitals that can and do seek and obtain additional funds from the public in the event that they incur a deficit during a given year; they are doctors of medicine who must depend entirely on the fees paid for service.

If a single corporation can be evolved that guarantees the control of the surgical plan that your committee feels the Society must have, it will be studied in detail and the findings of such a study made to this House. We foresee a difficulty at present by reason of the legislation as written in this State relative to both the hospital plan and the medical service plan.

The statutes for the incorporation of a nonprofit hospital service corporation provide that

"Sec. 2. (b) A majority of the directors of each nonprofit hospital service corporation *must be at all times* directors or trustees of *eligible hospitals.*"

The statutes providing for the incorporation of nonprofit *medical service* corporations provide that

"Sec. 9. Any nonprofit hospital service corporation organized pursuant to the provisions of chapter 719 of public laws 1939, may, with the consent of the Rhode Island Medical Society evidenced by the affidavit of the president and secretary of such society filed in the office of the secretary of state, amend its articles of association to adopt the provisions of this act and thereupon such corporation shall have and exercise *all of the powers* and be subject to *all of the duties* and responsibilities *of a nonprofit medical service corporation* to the same extent as though it had been incorporated as a nonprofit medical service corporation."

* * * *

The Rhode Island Medical Society has already given that consent (February 14, 1946). However, completion of a plan with active Blue Cross participation has prevented Blue Cross from becoming *the* medical service corporation in this State.

Your Committee directs to your attention that the complete surrender of future privilege to form a medical service corporation of its own is encompassed in this action, inasmuch as "no articles of association of a nonprofit *medical service* corporation shall be filed in the office of the secretary of state *unless and until* the governor of the state shall have certified in writing upon such articles that *he has determined* that *public convenience* and advantage will be promoted by the establishment of such corporation....."

* * * *

The Committee concludes this report with the reminder to the House of Delegates that it has conscientiously worked since its inception, and it will continue to work until it is discharged, in the interests of the medical profession and the people of this State. It was authorized to develop a prepaid surgical plan by whatever means available when the Blue Cross failed to cooperate in carrying out previous programs drafted by committees of the Society, and adopted by the House of Delegates. It has evolved a program that the Society has accepted, and that is now in operation and which permits Blue Cross participation. The failure of Blue Cross to participate rests entirely with that organization, and it is not due to any lack of cooperation by this Committee, or by the Rhode Island Medical Society.

Committee on Health Insurance

ROCCO ABBATE, M.D., *Chairman*
CHARLES J. ASHWORTH, M.D.
SAMUEL ADELSON, M.D.
J. MURRAY BEARDSLEY, M.D.
LOUIS CERRITO, M.D.
CHARLES L. FARRELL, M.D.
HENRI GAUTHIER, M.D.
ARCADIE GIURA, M.D.

COMMITTEE ON MEDICAL ECONOMICS
of the
RHODE ISLAND MEDICAL SOCIETY

Report to the House of Delegates, January 19, 1949

IN NOVEMBER, 1947, the Committee on Medical Economics submitted a report to the House of Delegates in which the following recommendations were made:

1. It is recommended by this Committee that all fees for examinations be increased.
2. It is suggested that the fee for an initial examination be at a minimum of $10.
3. Subsequent examinations should be consistent with the present office fee, but with a minimum of $3.
4. E. K. G. and interpretation should be a $15 fee.
5. Special examinations, such as blood and sugar tolerance tests, should be a $10 fee.

The House of Delegates adopted these recommendations. Subsequently every insurance company licensed in the State was notified, either through its local office, or directly through its home office. Also, the information was directed to every member of the Society on a special card notice.

During the past year there has arisen difficulties as the result of the action of the Society. Some physicians have not requested the suggested new fees, thus encouraging insurance companies to deny the increase to those physicians billing at the new rate. Some physicians have felt that the Society should collect the fees for them, a procedure that is not within the scope of the Society's activities. Some physicians have accepted the $5 fee under protest. Some physicians have complied with the Society's regulation and as a result have been denied referrals from insurance companies.

These situations were reported to the House of Delegates at its meeting in September, 1948. The House at that time ruled that a letter should be sent to every Fellow, and in addition a letter to each district Society secretary to be read at district society meetings, reviewing the action by the Society regarding insurance fees, and stipulating that this action was an official one of the Society which requires the response and the cooperation of every Fellow until such time as the action may be changed. These communications were subsequently sent.

Late in November the Council of the Society, in view of communications directed to it, asked that the Committee on Medical Economics render a further report on the entire problem to the House of Delegates. The Committee herewith supplements its previous reports to the House.

The fees for examinations for insurance companies have remained unchanged for 50 years, for the $5 fee for the initial examination is almost universal. The sliding scale fee schedule, based on the amount of the policy, is used by at least 23 companies.

Several state medical societies have long pointed out the inadequacy of the fees paid for physical examinations for insurance companies, and this inadequacy has been more noticeable in recent years with the altered value of the dollar. The New Jersey State Medical Society was one of the first to take action requesting an increase in the physical examination fee to $10, and as the physicians of that state encountered the same problems that we have met in Rhode Island, the House of Delegates of the New Jersey Medical Society passed a resolution last year which was transmitted to the House of Delegates of the American Medical Association asking for a national approach to the insurance fee question.

The Board of Trustees of the American Medical Association referred the resolution, adopted by its House of Delegates, to the Bureau of Medical Economic Research. That Bureau has consulted with the Committee of the Life Insurance Company Medical Directors which is making a survey of fees paid physicians for examining applicants for life insurance, and fees paid for reports from the attending physician who is frequently not one of the company's examiners.

The final report has not been compiled as yet. However, two important comments made by the chairman of the insurance committee to the AMA Bureau on Medical Economic Research are these:

1. The medical directors (of insurance companies) themselves will probably recommend that individual companies (240 companies in all) should raise the examination fee. They will not at this time specify the amount of the increase.

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2. The insurance companies may or may not act upon the recommendation of their committee of medical directors. If they do act it will be individually and not as an association.

The final report of the AMA Bureau will be filed with the Board of Trustees in April, and undoubtedly will be presented to the Association at the annual meeting in June, if not prior to that time.

In view of this pending report, your Committee would recommend that the Society maintain its position regarding the fees for insurance examinations since it is predicated on just and sound grounds. However, it is the opinion of the Committee that the House of Delegates might consider action for physicians to accept *under protest* a fee lower than those set forth by the Society pending a decision by the companies individually and collectively on the report of their medical directors referred to above, and pending a report from the American Medical Association later this year.

The Committee also calls to the attention of the House of Delegates the fact that it has information that 23 insurance companies pay a sliding fee based on the amount of the policy. From the physician's point of view the physical examination is and must always be complete and thorough for every patient, and the insurance premium or total liability involved should not be used as a factor in determining the physician's fee. Therefore the Committee would urge the House of Delegates to consider action recommending to the committee of life insurance company medical directors that this sliding fee schedule be discontinued.

Finally, the Committee commends to the House the action of the physicians of Newport County in taking united action to carry out the policy set forth by the Society in regards to insurance fees. The Committee recommends further that the House of Delegates take action to register a protest to the committee of life insurance company medical directors, against the use of Navy physicians doing these examinations for private patients in Rhode Island.

Committee on Medical Economics

WILLIAM P. DAVIS, M.D., *Chairman*
WILLIAM B. COHEN, M.D.
H. FREDERICK STEPHENS, M.D.
SAMUEL D. CLARK, M.D.
WILLIAM A. MCDONNELL, M.D.
LOUIS A. MORRONE, M.D.
EDMOND C. LAURELLI, M.D.
ALFRED M. TARTAGLINO, M.D.
HUBERT HOLDSWORTH, M.D.

DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

The Providence Medical Association met jointly with the Rhode Island Medical Society at the Officers Club of the United States Naval Air Station, Quonset, Rhode Island on Wednesday, February 2, 1949.

The meeting of the Association was called to order at 4 p. m. by Dr. George W. Waterman, President. Dr. Waterman stated that there was one matter to be brought before the members of the Association prior to the Scientific Assembly to be held jointly with the state society. He asked for a decision regarding the request from the Secretary of the state medical society as to whether the Providence Medical Association wishes to collect the special assessment of the American Medical Association or whether they would prefer to have the collection done through the executive office of the Rhode Island Medical Society. He called attention to the fact that the House of Delegates of the Rhode Island Medical Society had voted to support this assessment.

A motion was made that the special assessment of the American Medical Association on its membership who are members of the Providence Medical Association be billed and collected by the Executive Office of the Rhode Island Medical Society. The motion was seconded and unanimously adopted.

Dr. Waterman declared the business meeting of the Providence Medical Association adjourned so that the members might participate in the scientific program prepared by the Rhode Island Medical Society.

Dr. Joseph C. O'Connell, President of the Rhode Island Medical Society expressed appreciation to Captain Don Smith and Captain R. L. Weir of the Naval Air Station and to the Bureau of Medicine and Surgery of the United States Navy for making possible the meeting on this day, at the Quonset Naval Officers Club. Captain Smith extended the greetings of the Air Station and its staff to the members of both the Rhode Island Medical Society and the Providence Medical Association.

Dr. O'Connell introduced Captain Julius C. Early, Jr., MC, USN, Staff Member, Division of Aviation Medicine, Bureau of Medicine and Surgery, Navy Department of Washington, D. C. who spoke on "Some Aspects of Aviation Medicine".

The second speaker introduced by Dr. O'Connell was Captain Charles F. Behrens, MC, USN, Medical Officer in Command, Naval Research Institute, Bethesda, Maryland whose lecture was on the "Medical Aspects of Atomic Warfare".

At the conclusion of the scientific assembly, Dr. Charles J. Ashworth presented a resolution expressing the appreciation of the medical profession of Rhode Island to the Navy Department and particularly the Bureau of Medicine and Surgery and the commanding officers of the United States Naval Air Station at Quonset for their cooperation in making the meeting of the Society and the Providence Medical Association the success that it was.

The meeting was concluded with a dinner held at the Officers Club at which more than 200 members were in attendance.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.
Secretary

KENT COUNTY MEDICAL SOCIETY

The January meeting of the Kent County Medical Society was held on January 25, 1949 at the home of its president, Dr. Arthur E. Hardy.

The meeting was called to order at 9:30 p. m. and the Secretary's report of the December meeting was read and accepted.

Dr. Peter C. Erinakes gave a report of the business discussed at the last meeting of the State Society House of Delegates.

Dr. Arthur E. Hardy gave a report of the recent meeting of the Corporation of the Kent County Memorial Hospital, and said it was expected that construction on the hospital would begin in May or June of 1949 and it was expected to be completed about a year later.

The Society voted that the central office of the State Medical Society would be asked to bill for and collect the special A. M. A. assessment.

Following the business meeting, Dr. Orland F. Smith the director of the blood bank at the Pawtucket Memorial Hospital gave a very interesting talk on the establishment, function, and maintenance of a blood bank.

The meeting adjourned at 11:30 p. m.

Respectfully submitted,

JOSEPH C. KENT, M.D.
Secretary

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DISTRICT MEDICAL SOCIETY MEETINGS

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NEWPORT COUNTY MEDICAL SOCIETY

The Newport County Medical Society held a meeting at the Newport Hospital on January 25, 1949, with sixteen members attending. Invited guests and nurses from the Staff were present.

Communications were read.

Dr. Henry Fletcher moved that the State Medical Society bill and collect the A. M. A. Assessment from Members of this Society. The Motion was seconded by Dr. George Eckert and approved.

Following a discussion on Insurance fees, Dr. Samuel Adelson expressed the opinion that the policy established by the State Medical Society was not working out; that the plan was a failure at present and moved that this Society approve to do insurance examinations at the present fee schedule until arrangements are made for a higher fee. Dr. Lewis Abramson seconded this. The motion was approved.

On a motion of Dr. Lewis Abramson, seconded by Dr. George Eckert, the present officers of this Society were re-elected for another year. Dr. Henry Brownell, speaking for Dr. Callahan, who could not attend this meeting, stated that Dr. Callahan had expressed a desire to be replaced as Delegate to the Rhode Island Medical Society. No action was taken on this.

Two motions pertaining to the Blood Bank were introduced by Dr. John Malone, seconded and passed. These were: 1. that Dr. Frank Mayner, Mr. William Turner, and Dr. John Malone constitute an interim committee to purchase or procure all necessary equipment and material to set up a blood bank at the Newport Hospital, to be designated the "Newport County Blood Bank"; 2. that the Hospital Pathologist be the sole director of the Blood Bank, responsible to the hospital management and the medical staff for the proper conduct thereof; that in conjunction with the interim committee he shall organize the Bank in a suitable location in the Newport Hospital; that he cooperate fully with the Red Cross, the County Medical Society, Hospital Staff and representatives of the Massachusetts State Blood Program, for the purpose of obtaining adequate supplies of blood and blood derivatives.

A twenty minute film on the "Physiology of Normal Menstruation" was shown. Our guest speaker of the evening was Dr. Alex Burgess of Providence whose subject was "A Teaching Mission to DP Physicians". He pictured the sad plight of about a half million remaining displaced people in Germany and the efforts made by various agencies including the International Refugee Organization to aid these peoples. His particular endeavor concerned a teaching program in Munich to displaced Doctors and had as its basis the following objec-

tives: 1. to give information concerning medical progress from 1939 to 1948. 2. to give these men and women a "Moral Transfusion". 3. To convey to the people here the desirability and necessity of relocating and readjusting these useful men and women in this and other countries.

Respectfully submitted,

JOHN M. MALONE, M.D.
Secretary

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Earl Mara at 6:30 p. m. in the Nurses Dining Room of Memorial Hospital. Dr. Robert Henry gave a report from the House of Delegates relative to Insurance Fees and made mention of the inherent evils to the profession from overcharging private patients. This was elaborated upon by Dr. John F. Kenney, a member of the Committee of Ethics and Deportment.

The meeting then adjourned to the Nurses' Auditorium where the members were addressed by Dr. Harold Rosen of Phipps Clinic, Johns Hopkins University whose topic was "Psychosomatic Medicine." Dr. Laurence Senseman presided as Chairman.

The meeting adjourned at 9:30 p. m. Twenty-seven members attended.

Respectfully submitted,

KIERNAN W. HENNESSEY, M.D.
Secretary

WOONSOCKET DISTRICT MEDICAL SOCIETY

A special meeting of the Woonsocket District Medical Society was held on Friday, January 28, 1949.

The assessment from the American Medical Association was discussed and a motion was made and seconded that the society go on record as approving the assessment. The motion was passed by a majority of the quorum present.

A second motion to the effect that the central office of the State Medical Society handle the billing and collecting of this assessment was made and seconded and approved.

No further business came before the meeting.

Respectfully submitted,

ALFRED E. KING, M.D.
Secretary

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